Full Title: Piloting a 'Timeline of Crisis Tool' with service users on admission to an acute psychiatric ward

Running Head: Developing a Timeline of Crisis Tool

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Piloting a 'Timeline of Crisis Tool' with service users on admission to an acute psychiatric ward

Abstract

Objective: Being admitted to a psychiatric ward can be a distressing and confusing experience. Our objective was to develop and pilot a Timeline Tool as a way of supporting service users in developing a narrative of their experiences in the run up to admission.

Method: We designed and piloted a 'Timeline of Crisis Tool' with 50 inpatients, incorporating a card sort exercise, comprising eight factors relevant to people's experiences in the run up to a crisis admission. We asked service users for feedback on the experience of completing the Timeline Tool.

Results: Service user feedback indicated advantages of completing the Timeline Tool in terms of feeling listened to and respected, reflecting and making sense of experiences.

Discussion: Collaborative completion of the Timeline Tool on admission could help foster good service user-staff relationships. Information arising from the completed tool could be used to increase shared decision-making in the development of care plans during inpatient admissions.

Key words: *Inpatients; Mental Health; Crisis Intervention; Pilot Study; Personal Narratives*

Introduction

Being admitted to a psychiatric ward can be a distressing and confusing experience for service users experiencing an acute mental health crisis (Jones et al., 2010; Mind, 2011). The sense of chaos and confusion often associated with an admission can be compounded by the complexity of the admission process itself, which often involves contact with multiple agencies (Werbeloff et al., 2017). Difficult experiences of admission, particularly involving perceived coercion by mental health professionals, was highlighted as a key area that may limit recovery-focused care in a recent systematic review of service users experiences of inpatient care (Staniszewska et al., 2019). Clinical guidelines for psychosis and schizophrenia (the largest diagnostic group within inpatient care, (NHS Benchmarking Network, 2017) recommend people be supported to write a narrative of their admission to hospital in their notes to help make sense of their experiences (NICE, 2014). This approach is consistent with narrative-based therapies which have been shown to be effective in reducing self-stigma in people with schizophrenia-spectrum disorders, such as Narrative Enhancement and Cognitive Therapy (Yanos et al., 2019). Supporting people to write their own accounts of their mental health crisis may be helpful for them to better understand their experiences, reduce feelings of confusion on admission to hospital, and provide insights which might help them to stay well in the future. These benefits are likely to be relevant to users of inpatient care, across a range of diagnosis in addition to psychosis. A systematic review of qualitative studies of service users' experiences of inpatient care highlighted that people often reported low levels of control and involvement in their care plans; however where people did feel actively involved in care planning this was experienced as empowering (Lisa Wood & Alsawy, 2016). A collaboratively developed crisis narrative could therefore

also be used as a tool to enable greater levels of user involvement in care planning during an inpatient admission.

Previous work has focused mainly on the retrospective identification of factors leading up to a crisis once people have recovered, so that early warning signs can be identified and incorporated into a relapse prevention plan (Agius, Oakham, Biocina, & Murphy, 2006; Birchwood et al., 1989; Marland, McNay, Fleming, & McCaig, 2011; Perry, Tarrier, Morriss, McCarthy, & Limb, 1999). For example, the 'Back in the Saddle' approach to relapse prevention in psychosis provides a structured method of identifying relapse signatures (Birchwood, Spencer, & McGovern, 2000; Hewitt & Birchwood, 2002). This includes both a time line exercise, and a card sort exercise. The time line helps individuals to identify significant life events in the run up to the onset of their most recent episode, and the card sort helps them to identify early warning signs from a list of 55, and to put these in chronological order. Early warning signs include attenuated psychotic symptoms (e.g. thinking that other people can read your mind), and non-specific emotional and behavioural signs (e.g. irritability, difficulty sleeping). However, so far these timeline tools have mainly been evaluated in non-acute settings, with an emphasis on preventing further relapses, rather than primarily to help individuals to make better sense of a recent crisis on admission to hospital.

There has been a previous service evaluation project by Whittall and Allie (2011), which involved implementing a nurse-led 'narrative project' on an acute ward. However rather than using a timeline tool, service users were invited to narrate their experiences in an unstructured format to a nurse, who acted as a scribe, and provided occasional prompts when needed. However, they do report that one of the challenges of embedding their approach into practice was that nurses sometimes reported feeling a lack of confidence in their skills in

supporting service users with writing their narrative. Therefore, the development of a simple timeline with clear steps to the process could potentially help inpatient staff to feel more confident in the task, whilst drawing on their high-level therapeutic skills of talking, listening and empathising (McAndrew, Chambers, Nolan, Thomas, & Watts, 2014).

Our approach in this project was therefore to draw on the existing evidence base for the use of timeline tools and card sort exercises for relapse prevention, and to apply this to helping people develop a coherent narrative on admission to hospital. Given the paucity of research within inpatient settings so far, our primary aim was to collect feedback from service users as to whether they found completing the Timeline Tool an acceptable and helpful process.

Method

Development of 'Timeline of Crisis' Tool

We used multiple sources to develop the Timeline of Crisis Tool. Although the Back in the Saddle approach (Birchwood et al., 2000) includes 55 different warning signs in the card sort exercise, we were aware of the need to make the tool quick and easy to complete for an acute setting. This was important in meeting the needs of people who had experienced a recent crisis, who commonly experience problems with their concentration and thinking skills (Wood et al., 2019) due to multiple factors (e.g. intensity of symptoms, sedative medication). We therefore collected together categories of common relapse signs from the Back in the Saddle approach, a recent literature review on relapse indicators (Eisner, Drake, & Barrowclough, 2013), evidence on medication non-adherence prior to acute admission (Rittmannsberger, Pachinger, Keppelmuller, & Wancata, 2004) and expert opinion from local

inpatient clinicians. We included categories relating both to symptoms and the impact on functioning, as often it is behavioural changes which lead to someone being admitted to hospital, particularly when they relate to increased risk (e.g. self-neglect, aggression towards others). We purposely named the categories as neutrally as possible, to avoid imposing value judgements, and to make them as widely applicable to different people's experiences as possible. For example, we used 'medication' as a category rather than 'stopping/forgetting medication', and likewise 'sleeping' rather than specifying sleeping more or less than usual. The initial seven categories we used for the card sort exercise were 1) Mood 2) Sleeping 3) Eating 4) Washing/dressing 5) Medication 6) Social/family life 7) Getting out and about.

Procedure

We conducted an initial pilot phase on ward A, with a convenience sample of eight inpatients. The purpose of this was to check the acceptability of the wording of the categories, the time taken to complete the tool, and to get service user views on suggestions to amend or add to the timeline tool. The main suggestion we had from service users was to add a card for drug/alcohol use, as people highlighted this was often a problem for people in the run-up to a crisis, particularly as a maladaptive way of trying to cope with difficult thoughts and feelings. We therefore added this as the 8th card before proceeding to the main study.

The main study was conducted on ward B, which was a designated triage (acute assessment) ward for the local borough and accepted all new admissions for a period of seven days' assessment before discharge or transfer to a treatment ward. Data were collected as part of a service evaluation project, with R&D approval from the local NHS trust (reference

PSYAUD-15-44). Participation was voluntary, and all participants gave verbal consent to take part, which was witnessed by a member of the nursing staff, and recorded in their clinical notes. Participants were eligible to participate, within seven days of admission, regardless of recorded diagnosis or presenting symptoms, so long as they had capacity to consent, and did not pose a risk to the researcher. We set admission within the last seven days as inclusion criteria as the Timeline tool was designed to be used with someone in the early stages of their admission.

Recruitment took place on the ward once a week for six months. People who agreed to participate met with researcher (HK), who administered the Timeline Tool in a private room on the ward. In brief, participants were first asked to rank the eight cards in order of importance in the run-up to a crisis *in general.* Participants were then asked which cards they felt applied to them personally in relation to their recent crisis admission, and to then order these cards chronologically (see supplementary material for Timeline Tool and task instructions). After the Timeline Tool was completed, the researcher asked participants for feedback on what they found helpful/unhelpful about the process, and whether they had any suggestions for changing or adding to the tool. We also asked them to rate how helpful they had found completing the Timeline Tool on a scale of 1 (not at all) to 10 (extremely).

Data Recording and Analysis

As the primary aim of the study was to assess feasibility, we planned to report flow through the study in terms of number of new admissions screened, number eligible, number approached and number who participated. We define feasibility in terms of "can this be done?" To answer this question, we collected data on how many people approached agreed to

take part, how long the tool took to complete, how many people completed the tool once started, and how they rated their satisfaction with the process. We used a software package to calculate descriptive statistics (Statistical Package for the Social Sciences (SPSS) for Windows version 22.0). We read through the feedback comments as a team, and grouped similar comments together into superordinate categories.

Results

Out of 384 new admissions screened, 219 (57%) were assessed further for eligibility, and 153 people (40%) were subsequently deemed eligible to participate. Eighty-six of these were available to approach on the ward, with 36 declining (42%) and 50 agreeing to participate (58%). The sample included slightly more women than men (58% vs 42%), and the majority were from a Black or Minority Ethnic (BME) background (64%) which was representative of the population served by the Trust. The mean age was 39 years old, and the range was 19-60 years old. The sample was diagnostically mixed, including schizophrenia-spectrum disorder (32%), mood disorders (22%), substance misuse (10%) and personality disorders (6%). Approximately a quarter of participants (22%) had not yet received a formal diagnosis as it was their first presentation to services. Almost half of participants (48%) were detained involuntarily under a section of the Mental Health Act. Our sample included both people presenting to mental health services for the first time, and those who had been using services for many years. Out of those for whom this was not their first admission (54%), the average number of previous admissions was five, and the range was 1-20.

We found the Timeline Tool could be completed relatively quickly (5-10 minutes) in most cases. The tool was simple and achievable. No participant expressed distress directly relating to the process of completing the Timeline Tool. The mean average helpfulness rating was 7.4, with the modal response being extremely helpful (10/10).

Participant feedback is shown in Table 1. Most of the feedback on the tool was very positive, and related to people feeling respected, and listened to, and being supported to self-reflect. Seven people made minor comments about unhelpful aspects, e.g. that it was not always easy

to match things to clear categories (or "*pigeon-holing"* as one participant termed it). Most people felt the categories of cards were appropriate and comprehensive, although some people made suggestions for other things to add such as spirituality, and work.

INSERT TABLE 1 HERE

Discussion

Key findings

We conducted a service evaluation project on introducing a Timeline of Crisis Tool to help service users make sense of their crisis on admission to an acute inpatient ward. The results indicated that the Timeline Tool was feasible to implement within an acute inpatient setting, being quick and simple to complete, and the process was acceptable to service users. People who are admitted to psychiatric wards often report feeling dissatisfied because they feel they have low levels of control and involvement in their care plans (Wood & Alsawy, 2016). The use of such a Timeline Tool, which explicitly allows the service user to construct their own narrative, in a respectful, collaborative and validating way, may help in combatting this. This is important as more shared decision-making in care plans has been found to be highly wanted, yet under-used in mental health care, particularly for people with more severe difficulties (Beitinger, Kissling, & Hamann, 2014).

Clinical implications

The information arising from the collaborative completion of such a Timeline Tool might be of great help to the multi-disciplinary team (MDT) in planning care. This could include interventions specific to nursing (e.g. help with re-establishing good sleep habits whilst on the ward), pharmacological treatment (e.g. understanding factors underlying medication non-compliance) and psychological treatments (e.g. brief interventions on emotional coping skills). Collaborative completion of the Timeline Tool on admission might also help to improve the quality of the therapeutic relationship between staff and service users by helping to build trust and rapport. This is a vital process, as high-quality relationships with staff was found to be one of the key dimensions which positively influenced people's experience of in-patient care in a recent large-scale systematic review (Staniszewska et al., 2019).

Limitations

Feedback on the Timeline tool was elicited straight after it had been completed with the researcher; an alternative approach would have been to get another member of staff who was not involved in administering the Timeline tool to collect the feedback, to try to reduce demand characteristics (the tendency for people to produce the response which they think the researcher desires). An additional limitation of this study is that we did not collect data from multi-disciplinary members of the inpatient team about their views on the Timeline tool, and we do not yet know which members of the team would see it as an appropriate part of their role to be involved in administering it.

Directions for further work

Although we hypothesise that completion of the tool may improve staff-service user relationships, and may lead to more collaborative care planning, this remains to be evaluated in further larger-scale studies, including studies with an appropriate control group. If the Timeline Tool were to be more formally evaluated in a future trial, it would also be important to define what an appropriate outcome measure would be. This would depend on what the main aim of the Timeline Tool might be – for example, whether the primary aim is to improve staff-service user relationships, or to improve patients' experience of inpatient care. There may be considerable implementation challenges in trying to embed the Timeline tool within routine clinical care, if it were reliant on nursing staff alone to facilitate. This is because it is well documented that nurses on psychiatric wards often have limited time to spend in direct contact with patients due to the heavy burden of administrative and other ward tasks (Mullen, 2009; Rose, Evans, Laker, & Wykes, 2015; Sharac et al., 2010). Furthermore, Whittall and Allie (2011) note that some nursing staff in their project lacked confidence in working with service users on developing their narratives, and so further support and training may be needed. Relying on specialist therapy staff, such as psychologists, also poses implementation challenges however given that many wards offer either limited or no access to psychological therapies (The Commission on Acute Adult Psychiatric Care, 2015; CQC, 2009).

In conclusion, we found that a Timeline Tool was feasible and acceptable to service users within an acute inpatient setting, and this warrants further work on effectiveness and implementation.

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Data availability: The corresponding author has full access to the study data and is responsible for on-going access and archiving.

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Table 1: Service user feedback on the Timeline of Crisis Tool

1) What did you find helpful?	**Illustrative comments**
1.1 Making sense of your experiences	- *Understanding my own patterns* - *Made me realise what happens as I start to get unwell. It was all jumbled up before* - *Quite powerful, even for a piece of paper, and puts stuff into perspective properly* - *It allowed me to see what went wrong and when*
1.2 Feeling respected and listened to	- *Someone is listening to me, letting me explain* - *I find it helpful that you've heard something that I relate to* - *I appreciate the questions and talking about something open-minded*
1.3 Self-reflecting and being honest	- *I was able to open up. I was able to reflect* - *What I think is important; what my priorities are in life and my understanding about that* - *Just recalibrating what happens in this environment, because I've never really sat down and thought about it*
2) What did you find unhelpful?	
2.1 Difficulties categorising	- *Some of these things don't match and you have to rank them; they're apples and pears* - *Boxing things (pigeon-holing things) can be difficult.*

3) Suggestions for changes/improvements	*Cards to add/amend :-* - *Interests & hobbies* - *Holidays/trips* - *Separate cards for different moods e.g. anxiety* - *Personality* - *Spirituality* - *Self-image* - *Work* - *Health* - *Difficult experiences/hassles*